ILLINOIS DEPARTMENT OF Healthcare and Family Services

Prior Authorization Request Form
Byetta (exenatide injection)

Identification information

Patient Information (required):

Name:_____

DOB:_____

Nine-Digit IDHFS ID Number:_____

LTC Facility Information (if applicable):

Facility Name:_____

Phone:_____

Fax:_____

Physician Information (required):

Name:_____

Phone:_____

Fax:_____

State License #:_____

Pharmacy Information (if available):

Pharmacy Name:_____

Phone:_____

Fax:_____

HFS Provider #:_____

Clinical Information

All approved requests will be subject to quantity limits.

Medication: Byetta Strength:_____ Quantity:_____ Refills: _____

Directions for use: _____

1. What is the indication? ☐ Type 1 DM ☐ Type 2 DM Weight loss ☐ ☐ Other
2. Most recent hemoglobin A1c level: _____% Date drawn:_____
3. Has the patient been treated with maximally tolerated doses of metformin AND/OR a sulfonylurea OR a TZD for at least 3 months? Yes ☐ No ☐
4. Will patient continue therapy with: metformin ☐ sulfonylurea ☐ TZD ☐ Insulin ☐
5. Does patient have a contraindication or intolerance to: metformin ☐ sulfonylurea ☐ TZD ☐ Insulin ☐
6. Is either of the following conditions present?
   ☐ Severe renal impairment or ESRD (CrCL <30 mL/min) ☐ Gastroparesis or other severe GI disease

Additional Information:_____

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Please complete form and fax to 217-524-7264